Exhibit F

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

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IN RE: ETHICON, INC. PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION	:	Master File No. 2:12-MD-02327
	:	MDL NO. 2327
MARY K. BURNETT	:	JOSEPH R. GOODWIN U.S. DISTRICT JUDGE
v.	:	
ETHICON, INC., et al.	:	CASE NO. 2:12-cv-01795

- - -

July 21, 2016

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Expert deposition of BRIAN J. FLYNN, M.D., taken pursuant to notice, was held at Butler Snow LLP, 500 Office Center Drive, Suite 400, Fort Washington, Pennsylvania, beginning at 9:36 a.m., on the above date, before Kimberly A. Cahill, a Federally Approved Registered Merit Reporter and Notary Public.

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BRIAN J. FLYNN, M.D., after having been duly sworn, was examined and testified as follows:

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EXAMINATION

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BY MR. McCONNELL:

Q. Good morning, Dr. Flynn. My name is Bob McConnell. I'm one of the lawyers for the Motley Rice law firm and we represent Mary Burnett. I'm here to take your deposition today.

We're on the phone -- I'm not going to go through a list of instructions, but we're on the phone, so we should just be cognizant of waiting for me to finish my question and I'll try to wait for you to finish your answer, and I think we can get through this fairly easily.

Could you state your name and your occupation for the record, please?

A. Yes. I'm Dr. Brian J. Flynn. My occupation is, I'm a urologist and specialist in female pelvic medicine and reconstructive surgery. I'm a professor of surgery and urology at the University of Colorado in Aurora, Colorado.

Q. And what's your business address?

A. My business address is 1635 North Aurora Court, Aurora, Colorado 80045.

Q. And on the Mary K. Burnett case, when were you first contacted to do work on this case?

A. Sometime in maybe January or February of this year.

Q. Okay.

And what were you asked to do?

A. I was asked to serve as an expert witness on the behalf of Ethicon in this case.

Q. And what specifically did

that entail or what did you then go about to do?

A. They asked me to prepare an expert report and to perform an IME on Mrs. Burnett, so in order to do that, that included review of the medical records, preparation of a report, physically performing the independent medical evaluation.

I had already completed a general report on TVT Secur, so that was submitted, but that had been prepared previously.

Q. Now, you looked at Mrs. Burnett's medical records, I take it. What else did you review, if anything, document-wise?

A. Yes. I reviewed expert depositions of the physicians that are on the plaintiff's team, Dr. Jerry Blaivas' expert deposition. I also looked at all the pertinent medical records, looked at some company documents, including the IFU, patient brochures. That's primarily

what I did.

Q. Did you look at any depositions of treating physicians, Mrs. Burnett's treating physicians?

A. I did. I looked at the expert deposition of Dr. Gerald Shirk; Dr. Ann Metzger; and also of one other treater, Dr. Mindrup.

Q. Okay.

And did you also look at Mrs. Burnett's deposition?

A. I believe I did look at that deposition. I don't remember that as well, but I'm fairly certain I did look at that.

Q. And what documents have you brought with you to the deposition? Can you describe those for the record, please?

A. So I have a large binder, black binder, labeled "Dr. Flynn's Case-Specific Plaintiff Mary Burnett." And this is, you know, a medium-size binder with at least 30 tabs in it.

In the binder, that would include my case-specific report, my IME report, some pertinent medical records, and then my reliance list.

In the front envelope in that binder, there is a USB that's blue and it has a tag on it. It says "Flynn, July 14th, 2016 Deposition, Burnett Materials."

Q. Okay.

A. So that -- that's one item. Would you like me to continue?

Q. Well, you know, why don't we -- for the record, I'd like to have that marked as Exhibit 1 in its entirety. And I'm going to ask you about the -- your expert opinions and also the examination you did, so just so you know, those will be the two documents specifically I'm going to inquire on.

But I'd like to have that binder that you just described marked as Exhibit 1, including the USB device. And that's it for that binder, Doctor.

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(Deposition Exhibit No. Flynn-Burnett-1, "Dr. Flynn's Case-Specific Plaintiff Mary Burnett" Black Binder Containing Reports, Records, and "Flynn, July 14th, 2016 Deposition, Burnett Materials" USB, was marked for identification.)

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MR. McCONNELL: What else did you bring?

THE WITNESS: I have an updated C.V. that was updated on June 28th, 2016.

MR. McCONNELL: Okay.

THE WITNESS: I have an invoice that had been prepared and submitted in June of this year.

And I also have the AUGS position statement in regards to mid-urethral mesh slings for stress urinary incontinence.

BY MR. McCONNELL:

Q. Anything else?

A. That is it.

I have given a number of depositions similar to this, so I previously have submitted a list of deposition and trial history. I've submitted a fee schedule in the past. I've submitted e-mails in regards to communications I've had with Ethicon in these cases, so I didn't bring those items, as I've submitted them in with wave 1 depositions.

MR. McCONNELL: For the record, why don't we mark the updated exhibit -- I'm sorry -- updated C.V. as Exhibit 2.

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(Deposition Exhibit No. Flynn-Burnett-2, Curriculum Vitae of Brian J. Flynn, M.D. Updated 6/28/16, was marked for identification.)

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BY MR. McCONNELL:

Q. Doctor, I just can't read my note. For Exhibit 3, what was the next thing you said after the C.V.?

A. Invoice.

MR. McCONNELL: Okay. We'll do, the invoice will be 3. And the AUGS document will be 4.

- - -

(Deposition Exhibit No. Flynn-Burnett-3, 6/16 Invoice, was marked for identification.)

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(Deposition Exhibit No. Flynn-Burnett-4, AUGS Position Statement, was marked for identification.)

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BY MR. McCONNELL:

Q. Doctor, I don't have the invoice in front of me. How many hours have you spent on this -- on the Burnett case?

A. Let's see. I've spent 18 hours.

Q. And what is your hourly charge?

A. It depends on the activity, but it would range from $400 for record review, $500 for preparation of the report, IME at $550 an hour.

Q. Okay. And how about deposition time?

A. That's not included in this report, but the hourly rate for that is $600.

Q. And I'm sorry. Did you say you've spent to date 18 hours?

A. 18 hours up until May 31st.

Q. And since May 31st, which was a month and a half ago, can you ballpark how much time, if any, you've spent on this case?

A. Yes. I've spent approximately ten hours since then.

Q. And what have you done in those ten hours?

A. I've reviewed depositions, the ones I mentioned earlier, from Dr.

Blaivas and others as they've come in, and I have reviewed the medical records once again, reviewed my report and my IME. I have met with Mr. Snell.

This deposition was going to occur, I believe, last Thursday and so I had prepared for that, but -- so those were the activities.

Q. You wrote out a formal report and a formal IME. Have you written any other document as it pertains to the Burnett case, including handwritten notes or anything of that nature?

A. I had handwritten notes for the IME on Mrs. Burnett. I didn't bring them. I'm not in my home office. I'm in Philadelphia, as you know.

So I do have those. I could submit them at another date, but I didn't bring that today.

MR. McCONNELL: Okay. I think we -- I think for completeness sake, we'd request

that you do submit those to counsel and they'll provide them to us, I'm sure.

BY MR. McCONNELL:

Q. Any other handwritten or -- any other writings that you've done on this case that you haven't described or aren't contained in Exhibit 1?

A. No.

Q. Doctor, can you turn to your -- the document entitled "Independent Medical Exam of Mary Burnett" with date May 18, 2016, which I assume is included in Exhibit 1?

A. Yes.

Q. Do you have that in front of you?

A. I do.

Q. Okay. I'm going to have a series of questions about that. The first question I had was, the location is office of Dr. Steven Geraghty. Is that your business address as well?

A. No, that's Dr. Geraghty's

business address.

Q. Why did you perform your exam of Mrs. Burnett at Dr. Geraghty's office?

A. Bowman and Brooke had arranged for me to perform the IME there. I don't have the exact question -- answer, but that's where I've done all the IMEs that I've performed in this litigation.

Q. Is your office not capable of holding an IME exam?

A. No, they're not capable.

Q. Why is that?

A. It's not part of the ordinary practice, so it's very difficult to schedule there and to accomplish an IME there.

Q. Who is Dr. Steven Geraghty?

A. I don't know him personally. He's a family physician, family practitioner, in Centennial, Colorado.

Q. Now, did you interview Mrs. Burnett as part of your medical exam?

A. I did. That was the majority of time spent with her, was during the face-to-face encounter.

Q. And approximately how long was that interview?

A. Well, the entire IME was one hour, of which the interview part of that was 80 percent of the time, so 50 minutes.

Q. Okay.

Did you take any -- are those the notes you referred to, the handwritten notes?

A. That's correct.

Q. So you have handwritten notes from that interview?

A. Yes. What I do is, with any of the patients I see in my practice or in the IME, I have a template, you know, that has the key areas of the history and physical, and then I fill in the blanks with my handwritten notes and then after that prepare the electronic note.

Q. Was anyone else with you and

Mrs. Burnett while you interviewed her?

A. Yes, there was a medical assistant from Dr. Geraghty's office.

Q. And what was her role during the face-to-face interview?

A. She was there at the request of the plaintiff. Ordinarily, the medical assistant would be there just for the physical examination, but there was a request made for her to be there for the entire IME, so we honored that request.

Q. And who specifically made that request?

A. I believe it came from Mrs. Burnett's attorneys.

Q. Now, as part of your discussion or interview of Mrs. Burnett, did she discuss any concerns she had about further surgery with you?

A. Yeah, we discussed the surgeries that she had and what her future prognosis or surgery -- you know, what sort of things she would need to have done.

Q. Did she say that she was concerned or anxious or worried at all about further surgery?

A. Yes.

Q. And what did you -- did you have a reply to her about that or did you have a discussion with her about that?

A. I did.

Q. And what did you say?

A. I said that it wasn't part of the IME for me to share with her my opinions and prognosis and make recommendations to her, so I informed her that I wasn't going to discuss that with her.

Q. Did she bring that up to you or did -- how did that topic even get raised then?

A. At the very end of the encounter, similar to what would happen, you know, in my everyday practice, she asked what was wrong with her and what needed to be done in order to address her concerns.

Q. Did she discuss any concern that she had about mesh potentially causing damage to a partner in a sexual way?

A. We discussed her sexual habits and her love life. I don't remember her specifically asking me if there would be concerns about her partner.

Q. Well, what I asked was, did she say she had concerns that the mesh could do some damage to her partner in a sexual encounter.

A. I don't recall her asking me that question.

Q. And what do you recall about your discussion of her sexual habits and love life?

A. She mentioned to me that she was married three times; that she was currently widowed; that her most recent husband had died of bladder cancer and he had his bladder removed. He had a urostomy. And after that surgery, he was

unable to perform sex. He was impotent.

And she had not had a sexual encounter since 1993, and she is not dating anybody currently since the death of her third husband.

Q. How old is Mrs. Burnett?

A. Mrs. Burnett at the time I met her was 65 years of age. It looks like she had a birthday [redacted] after I had met her, so she's 66, I believe, at the time -- currently.

Q. Can you turn to page 4, Doctor, of your medical report or medical exam?

A. (Witness complies.) Yes.

Q. And in that, you list various categories of examination that you did under "Genitourinary"? It's at the top of the page.

A. Yes.

Q. What is estrogenization? Where you say severe atrophy, what is estrogenization?

A. That's a comment that I make

when examining the effects of estrogen on the genitalia and on the vagina.

So, you know, estrogenization would imply that there's estrogen in the tissue, making the tissue soft and supple, versus atrophic or dry on the opposite end, and then there's some patients that are in between.

So it's a comment reflecting the -- my visualization of the effects on estrogen on the female genitalia.

Q. And severe atrophy, I'm sorry, means what?

A. Well, atrophy means a shrinking of the tissue, and severe would mean that -- you know, I would say mild, moderate, and severe are the categories that I would use, so that's a reflection of genitalia that has not seen the effects of estrogen in a very long time.

Q. And further down, under "Vagina," you make some findings. There was blue mesh exposed that -- and various findings. There's a paragraph of

findings there.

And I guess my general question is, can you describe how you performed this examination and how did you go about seeing things? Did you physically measure things?

Just basically describe the process you took on this examination, please.

MR. SNELL: Object; form.

Go ahead.

THE WITNESS: So after I performed the history, then we went into the physical exam portion. Specific to the genitourinary exam portion of the procedure, the patient is in a lithotomy position, meaning she's lying on her back with her legs in stirrups. The medical assistant is standing next to me. There's a sheet overlying the patient's thighs and knees, and I'm sitting down.

Initially, I will inspect the external genitalia just with my eyes and manually manipulate the tissue; and then once the external genitalia is inspected, I will then ask permission to insert a speculum or a finger into the vagina to palpate, to feel the tissue. So the vagina part of the examination is both with a clear plastic speculum as well as manually or digitally.

During that time, I'll ask the patient to cough, to strain, meaning a Valsalva maneuver, what we call a cough stress test. While I'm looking with the clear speculum, I'm looking for any kind of vaginal foreign body. I'm looking for the effects of estrogen. I'm looking for pelvic organ prolapse, looking to see if there's any evidence of any malignancy. I'm looking to see if

there's a cervix.

So that's what I'm primarily performing during that portion of the examination.

BY MR. McCONNELL:

Q. Okay.

Now, you noted, in that paragraph, blue mesh. What, if anything, did that indicate to you?

A. So mesh comes in a variety of different colors, primarily clear mesh or blue mesh. I like to distinguish whether it was a clear mesh or blue mesh.

Occasionally, we don't know what type of mesh was implanted and so we could infer from the color of the mesh what type of mesh it is.

So I could clearly see that it was blue and that it was a mesh. I could see that it was not a stitch. I can see that there was a knit of fibers. I didn't use a ruler to measure the 5 by 9 millimeter exposure, but I know that the width of my thumb is 10 millimeters

in width, so sometimes that's a -- just an easy way for me to use as a measuring stick, so it was just slightly less than the width of my thumb in its greatest dimension, 9 millimeters; and then in the opposite direction, it was half of that, so 5 millimeters.

Q. And what does the blue mesh infer to you?

A. The blue mesh, that it could be a mesh from -- it could be an Ethicon mesh. Some of the Ethicon meshes are blue. Some of the original meshes, like the original TVT, was clear, but TVT Exact or TVT Secur are blue. Boston Scientific has blue meshes, so it possibly could be a Boston Scientific device.

American Medical Systems and Bard Urology, Coloplast, others, the majority of the other meshes are clear meshes. Some of the meshes may have more than one color. Maybe they have a blue and clear fiber weave, so I'm just

referring to simply the color of the mesh.

Q. And you also made a finding of no pain. How did you measure that?

A. I used the pain scale that's commonly utilized called the visual analogue pain scale. It's a widely recognized score that physicians use when assessing pain with patients.

I explained to the patient ahead of time I'm going to assess your pain. Zero would mean no pain. Ten would mean the worst pain imaginable; and then as I examine, I ask them to grade the pain.

Q. And 0 over 10, does that indicate that Mrs. Burnett exhibited no pain or relayed to you no pain during any of your exam?

A. That's correct.

Q. Can you turn to page 5 under "Assessment and Opinions," please?

A. (Witness complies.)

Okay.

Q. Under "Vaginal Mesh Exposure," you say that this would be classified as a grade 2 complication. What are the -- what are the range of grade complications?

A. I believe the grading system goes from 1 to maybe 8. The ones that I commonly see in my practice would be 1, 2, 3, and 4.

So I'm familiar with the grade 1 complication would be a patient that had pain that was palpable over their mesh, but there was no actual exposure of the mesh.

A grade 2 would be that there was an exposure of the mesh that was less than 1 centimeter. Grade 3 would be more than 1 centimeter. Grade 4 is a mesh perforation into the lower urinary tract, including the urethra and the bladder.

Grade 5, 6, 7, 8, I'm less familiar with as I don't really see those in my practice.

Q. Are those -- is 5, 6, 7, 8 on the more severe end?

A. Yeah. So the grading system goes from the least severe to the most severe.

Q. The -- now, you say, this is easily treated with partial transvaginal mesh excision. What is the basis for your opinion that this exposure is easily treated?

A. That would be based on my education, based on my experience in practice treating similar patients. That would be based on my review of the medical literature.

Q. But what specifically can you point to as part of your examination of Mrs. Burnett that allows you to reach that conclusion?

A. So if we go back to the grading system, the lower the grade, the easier to treat. If the mesh, say, for instance, was a grade 4 into the lower urinary tract and you removed it, you

would then have to repair the urinary tract, in other words, you know, place sutures in the urethra or the bladder to fix a hole or opening.

Those are more time consuming. They require a catheter afterwards. There's a greater likelihood of them developing stress urinary incontinence afterwards.

Obviously, if it's eroding or perforating into the GI tract, the intestinal tract, that would be a much harder one to fix.

Q. Okay.

A. So, you know, a vaginal wall mesh exposure tends to be the simplest of all the complications to treat.

Q. And have you treated grade 2 complications in the past?

A. I have.

Q. And have they all been easily treated?

A. The overwhelming majority of them.

Q. What are some examples of grade 2 complications that aren't easily treated? What happened?

A. That would be a patient that had a recurrence of the exposure. That would be a patient that, you know, had injury to the lower urinary tract during the removal or had bleeding that occurred. Those things are more likely to occur when removing larger pieces of mesh or attempts at, you know, total or complete mesh removal.

So the potential complications depend a lot on how the -- how the surgery's done.

Q. Now, did Mrs. Burnett have a recurrence of exposure during any of her treatment?

A. I believe she initially had an in-office mesh excision with Dr. Shirk in 2008, so this would be considered a recurrent mesh exposure.

Q. And those fall into a category of potentially not so easily

treated, correct, or a complication?

A. That's not correct.

Q. Okay.

Well, I think I asked you previously what would be potential complications and you said a recurrence of exposure; correct?

MR. SNELL: Object; misstates.

Go ahead.

THE WITNESS: What you asked me was, can you give me some examples of which ones would be, you know, harder to treat, that would not be easy. And that's a big category. Each one of those is different.

Most physicians have moved away from in-office mesh excision or what's known as trimming because that has been shown to be ineffective.

So it depends on how the initial patient was managed. I

know at least in my practice, the overwhelming majority of the patients have one excision and don't require subsequent excisions.

So this patient, if I managed her, I could do this in a one-hour outpatient procedure and I would expect that there would be less than a 5-percent chance of her having a subsequent exposure.

BY MR. McCONNELL:

Q. But, in fact, she has had a subsequent exposure already in this case; correct?

A. Correct, or possibly persistence. I don't know if the problem was ever, you know, managed in 2008.

Q. And you also later on in that paragraph decide that she may also choose to live with chronic mesh exposure; correct?

A. Correct.

Q. What are the risks of living

with chronic mesh exposure?

A. The main risk is, if there's symptoms that are attributable to the exposure, that they would continue.

Q. And what are those symptoms -- in Mrs. Burnett's case, what are those symptoms?

A. In Mrs. Burnett's case, she doesn't have any symptoms. There's no symptoms of the mesh exposure.

Q. What if she were to become sexually active?

MR. SNELL: Object; form, hypothetical.

Go ahead.

THE WITNESS: If she would become sexually active, there's a possibility that either her or her partner would experience discomfort during sexual intercourse.

BY MR. McCONNELL:

Q. Okay.

In paragraph 2, "Recurrent

Mixed Urinary Incontinence," do you see that?

A. I do.

Q. About the third sentence in, third or fourth sentence in, you say, "Her SUI has been present since 2007, one year before her TVT Secur procedure."

Now, is that a typo, Doctor?

A. I don't believe so. I probably could have stated it a little more clearly, but what I'm saying there is that her SUI began a year before she elected to have surgery for it.

Q. And I may be reading it wrong, but didn't -- wasn't her surgery in 2007, in January?

A. In January of 2007, she had her surgery, so -- so, yeah, it should be her SUI has been present since 2006, so you were reading it correctly. I should have said her SUI's been present since 2006.

Q. Okay.

You can point -- so that's a

-- that is a typo.

A. That would be a typo.

Q. Okay.

And you can point to something in her record that indicates her SUI began in 2006?

A. I would have to go back and look at Dr. Shirk's notes, but I believe he had been seeing her and Dr. Ann Metzger had been seeing her prior to January of 2007, so there would have been an evaluation period leading up to the surgery.

Q. But under any circumstance, we both agree her surgery for the mesh implant was in January of 2007; correct?

A. I'm going through the medical records just to confirm the surgery date, but I believe that that was the date when I -- I reviewed the records last.

So I'm looking at an operative report here. This is in my binder under the first tab, TVT Secur,

Gerald Shirk, January 26, 2007. So, yeah, that's the date of the surgery, January 26, 2007.

Q. So with that in mind, how would you amend that statement, if at all?

A. The simplest way to amend it was that she had incontinence that existed sometime before 2007.

Q. Now, later on in that paragraph -- or the bottom of that paragraph -- excuse me -- you say: Surgical therapy may include transurethral bulking agent, mid-urethral sling, or pubovaginal sling.

Correct?

A. Correct.

Q. Now, are you recommending Mrs. Burnett undergo additional surgery after having spoken to her for an hour about her concerns about future surgery?

MR. SNELL: Object; form.

THE WITNESS: No, I didn't make recommendations to her. What

I recommended was that she have her urodynamics repeated. I don't believe that that's been done since in the preoperative evaluation before her 2007 surgery.

So what I'm recommending is that when you have a mixed picture, meaning some complaints of stress incontinence and some complaints of urgency incontinence, in a patient that's had prior antiincontinence surgery, what the AUA guidelines would recommend is that this patient undergo a urodynamic evaluation to assess the type of incontinence in order to appropriately direct future therapy.

BY MR. McCONNELL:

Q. But you do list as a future treatment option potentially surgical therapy, including mesh -- mesh slings.

A. Yeah, I listed transurethral bulking agents, mid-urethral sling which is synonymous with mesh slings, and pubovaginal sling.

Q. Okay. And you do list that as a future option, even though you are aware of Mrs. Burnett's concerns about the mesh and future surgeries; correct?

A. These are future options that exist for patients with mixed urinary incontinence, including Mrs. Burnett. It would require informed discussion, reviewing the options with her. You'd have to look at how her existing mesh exposure was managed. All of those things would have to come into consideration.

Q. But if she were your patient, knowing her feelings, would you still recommend future mesh surgery for this patient?

MR. SNELL: Object; form.

THE WITNESS: It would depend on how she would elect to

have her existing exposure managed. That's the first decision point.

So I can't say what future decisions I would make until -- the first issue listed in the assessment/opinions number 1 would need to be addressed before you can make recommendations on number 2.

BY MR. McCONNELL:

Q. In paragraph 3, you say in the third or fourth sentence down, middle of the paragraph: Her UTIs are not caused by the TVT Secur mesh or vaginal mesh exposure.

Do you see that?

A. I do.

Q. And can you give me the basis for that statement?

A. The basis for that statement is, I don't see anything in the medical record to support the TVT mesh being the cause of her urinary tract infections.

Q. And what led you -- what specifically leads you to that conclusion? You didn't see anything in the medical records. What do you mean by that?

A. I didn't see any information on culture of the mesh or culture of the urine that would implicate that the mesh was the cause.

So, for instance, if the urinary tract infections were always E. Coli and someone had cultured the mesh and that was E. Coli, well then, that would suggest that possibly the mesh is a cause.

If the mesh was perforating into the lower urinary tract, that would be more likely a cause. That's not what's occurring in this case.

So those opinions are based on the type of IUGA complication. So this is a grade 2, so for grade 1, 2, and 3, I think it's much -- it's unlikely that that would be the cause of the UTI.

If it's perforating into the lower urinary tract, then that would be more suggestive that that's the cause of the UTI.

Other considerations is, if the mesh was causing urethral obstruction and bladder incomplete emptying and a need for clean intermittent catheterization, then that story would be more suggestive as being a cause. That's not occurring in this case; and I believe when she saw Dr. Blaivas, he's ruled out urethral obstruction as being a cause.

So people that I see with recurrent urinary tract infections due to prior antiincontinence surgery, it's usually someone that's using a catheter or someone with a perforation into the lower urinary tract, and she doesn't have either of those.

Q. Okay.

Can you turn to your opinions regarding Mary Burnett? It's a separate document.

A. (Witness complies.) Okay.

Q. On number 12 -- these are all numbered, the paragraphs -- paragraph number 12, you state that mesh exposure at three months' postop is most likely due a technical error and not a product defect.

Do you see that?

A. I do.

Q. And what do you mean by a technical error in that statement?

A. Technical error would imply that there's wound failure, so her wound failed or what we call healing abnormalities.

But what I see ordinarily in my surgical practice, regardless of the location of the incision, when the incision breaks down and the underlying tissue or foreign body becomes exposed, then that's usually related to a stitch breaking or not enough stitches being placed or tension on the incision. All of these things would fall under the

broad category of wound failure or technical failures.

Q. Did you see any of that in Mrs. Burnett's case?

A. I believe when Dr. Gerald Shirk had performed the postop examination early on, he immediately noted a mesh exposure, so, yes, I think he saw that the wound had separated and the mesh was exposed.

Q. And the mesh exposure was caused by the mesh implant; correct?

MR. SNELL: Object; form.

THE WITNESS: No, that's not correct.

BY MR. McCONNELL:

Q. Well, if there had been no mesh implant, would there be a mesh exposure?

A. The word mesh exposure, yeah, you have to have mesh to have an exposure. But there's many causes of mesh exposure, not just the mesh so --

Q. Right. But to start at the

beginning, if there's no mesh, there's not going to be any mesh exposure. You'd agree with me on that; correct?

A. Correct.

Q. Now, did you agree with Dr. Shirk that Mrs. Burnett was an appropriate candidate for a mesh implant?

A. There are a few things in the medical record that aren't clear preoperatively, but at least from what was available to me or what was performed by Dr. Shirk, it did seem like she was a reasonable candidate.

Q. And do you agree that Dr. Shirk followed proper surgical procedure in implanting the mesh into Mrs. Burnett?

A. Let me flip to his operative report here.

Q. Okay.

A. I don't recall reading anything unusual in the operative report. It's a one-paragraph report.

He made a 1 1/2 inch incision into the vaginal mucosa. He

created a dissection plane 2 centimeters deep.

There's not a lot of detail on how he placed the TVT Secur. It just says the Secur was placed in the U position.

I don't see anything that's standing out at me, but without having been there, there's just not a whole lot of detail in this report.

Q. So you have no reason to opine that Dr. Shirk did not follow proper surgical procedure in this implant; is that correct?

A. That's correct.

Q. Number 13, paragraph 13, Dr. Flynn --

A. Yes.

Q. -- now, do you recall -- you mentioned Dr. Metzger feeling a sharp edge. And you reviewed her deposition; correct?

A. I did.

Q. Do you recall her reaction

to how -- to when she felt the mesh?

MR. SNELL: Object; form.

THE WITNESS: Recall her reaction? I believe that, you know, she made Mrs. Burnett aware of what she felt. I believe that she had said in her deposition that it cut her glove, is a comment that I read in one of the depositions, I believe.

BY MR. McCONNELL:

Q. And that she found the sharpness of the mesh alarming? Do you recall that?

A. I do.

Q. Does any of that testimony of Mrs. Burnett's treating physician factor into your opinion as to -- or any of your opinions in this case?

A. Well, certainly I reviewed Dr. Metzger's notes in detail and her deposition and her interactions with Mrs. Burnett, so, yes, that affects my opinions. Dr. Metzger has been seeing

this patient for a number of years.

Q. And in what way does it affect your opinion?

A. It affected my opinion to the point that I included this in my report. You know, paragraph number 13 describes that finding that she made, so it was significant enough that I elected to put it in my report.

Q. Did it affect your opinion in this case in any other way other than what you've described in paragraph 13?

A. I struggled a little bit with her description of the location. Maybe she misstated or corrected this in her deposition, but at least in her medical record, she said 9 o'clock in the vaginal vault.

The vaginal vault is what we would consider the apex of the vagina where the cervix was. That's some 13 centimeters from the vaginal introitus.

So, typically, a mesh at the mid-urethra would be no more than 2

centimeters from the urethral meatus, so I was especially surprised by the location when she said that she felt something sharp at the vaginal vault. That would lead me to believe that maybe she was feeling the vaginal cuff scar or that she was feeling something else.

She said it felt like mesh, but she didn't definitively say it was mesh. She didn't call it a blue mesh. She didn't comment on the color of the mesh. She didn't mention if she can visualize it with a speculum.

So I -- that's what was surprising to me, is just the location.

Q. But you don't have any doubt that what she felt was the mesh; correct?

MR. SNELL: Object; misstates.

THE WITNESS: That's incorrect. I do have some doubts, because I believe she was feeling the vaginal cuff; and unless the mesh was placed at the vaginal

cuff, which would have to have been a surgical error by Dr. Shirk, the mesh can't move from the mid-urethra to the vaginal cuff.

So either Dr. Metzger meant to say the anterior vaginal wall when she said vaginal vault or Dr. Shirk placed the mesh at the vaginal apex, which I know he didn't because when I examined Mrs. Burnett, I can see the mesh 1 centimeter from the urethra. I commented on that in my IME.

So I know if you're 1 centimeter from the urethra, you can't be at the vaginal vault at the same time.

BY MR. McCONNELL:

Q. So with that explanation, what do you think it is most likely about what Dr. Metzger felt?

MR. SNELL: Object; form, asked and answered.

THE WITNESS: I'm not certain. I know that she's feeling some scar tissue -- that could be scar tissue from her hysterectomy -- or she didn't document in the record correctly where she was feeling the mesh or -- I don't remember what she said in her deposition about that comment. I'd have to go back and reread that.

BY MR. McCONNELL:

Q. Well, scar tissue wouldn't almost cut her -- or wouldn't cut her glove, would it?

A. Could scar tissue cut a glove? No, I don't believe so.

Q. Could mesh cut a glove?

A. I think that's extremely unlikely. It's never happened to me.

Q. Of the two, what would be more likely to cut a glove, scar tissue or mesh?

A. I think they would be

equally -- both of them would be equally unlikely.

Q. But of the two, which would be more likely to cut a glove?

MR. SNELL: Object; asked and answered.

THE WITNESS: I think it's a tie. I think -- either scenario has never happened to me in thousands of pelvic exams. And I've examined a number of women with mesh exposures. I've surgically removed exposed mesh. I've never had a glove cut from mesh.

BY MR. McCONNELL:

Q. But Dr. Metzger did; correct?

MR. SNELL: Object; form, foundation now.

MR. McCONNELL: At least according to her testimony.

MR. SNELL: Same objections.

THE WITNESS: I'm not going

to agree to that. She stated that she cut her glove, but I'm not certain she was feeling mesh.

BY MR. McCONNELL:

Q. But you don't know what she was feeling; is that what you're saying?

A. If it was at the vaginal apex, she was not feeling the mesh. So, you know, I'd have to hear her answer to that question to know what she was feeling, but at least according to the medical record, it states that she was feeling at the vaginal vault.

That's not the location of the mesh. Based on my exam, based on Dr. Blaivas' exam, based on Dr. Shirk's, Dr. Mindrup's, the mesh has never been at the vaginal vault.

Q. But you know according to her testimony which -- you said that she felt -- she was describing the mesh and she felt it was alarming that the mesh cut her glove; correct?

MR. SNELL: Object; lacks

foundation, form.

THE WITNESS: That's what she stated in the deposition, but I don't believe she's ever reconciled that with the statement of being at the vaginal vault.

BY MR. McCONNELL:

Q. In numbered paragraph 32, you state in the middle of that paragraph that Dr. Blaivas hypothesizes that there could be mesh perforation into the bladder or urethra; correct?

A. Correct.

Q. Did Dr. Blaivas in his report or deposition say he was hypothesizing?

A. I don't believe he used the word "hypothesis," but he implied that the mesh could be inside the lower urinary tract, and there's no foundation for that. That's speculation.

Q. Well, according to you, why does he -- in his opinion, why does he believe there could be mesh perforation

into the bladder or urethra?

MR. SNELL: Object; form.

THE WITNESS: I don't believe that was his opinion. I believe he was listing a differential diagnosis of all the things that could possibly be occurring, but I don't believe that he was implying that.

What we do know is that her most recent cystoscopy, less than two years ago, performed by Dr. Mindrup, her urologist, had showed that there was no perforation into the lower urinary tract.

BY MR. McCONNELL:

Q. In paragraph 34, you say you reviewed Dr. Rosenzweig's report and you disagree with his opinions that TVT Secur and laser cut mesh are defective products. And you say: Laser cut mesh mid-urethral slings are commonly used today by myself and most pelvic surgeons.

Did I read that correctly?

A. You did.

Q. Therefore, are you saying that a product can't be defective because it's commonly used?

A. There's two statements there. It says, laser cut mid-urethral slings are used commonly today by myself and most pelvic surgeons. So I think that statement is very straightforward. And that's true. If you look at the AUGS statement that I brought, if you look at surveys of their members, if you ask me questions about what I use in my practice, most pelvic floor surgeons continue to perform mid-urethral slings. Most mid-urethral slings 2016 are laser cut.

The first statement reflects to -- just that laser cut mesh is defective, and I don't believe laser cut mesh is defective.

Q. But the second statement comes after the first statement and my question is, is it your opinion that a

product can't be defective because it's being commonly used? Is that what you meant to say there?

MR. SNELL: Object; form.

Go ahead.

THE WITNESS: That's not what I meant to say and that's not what I said. It's not a compounded sentence. There are two independent statements. So --

BY MR. McCONNELL:

Q. One following the next in the same paragraph.

A. Yeah. If a mesh is used commonly, I would say it's very unlikely to be defective if it's been on the market for many years and used by 95 percent of AUGS members who have, you know, tens of thousands of years of combined experience using these products, performing these surgeries.

So, you know, I would say that it's a lot less likely compared to, say, a new product that we have little or

no information on.

Q. Okay.

In paragraph 35, you discuss -- you attribute the exposure to estrogen/hormonal deficiency; correct?

A. Correct.

Q. Doctor, do most women as they age experience vaginal atrophy?

A. Most postmenopausal women experience vaginal atrophy.

Q. And that's a natural occurrence?

A. That's a natural occurrence with aging.

Q. And the mesh implant is a permanent implant?

A. It's meant to be permanent, yes.

Q. Would you therefore expect that mesh exposure in most women with this type of permanent implant as they age?

MR. SNELL: Object; form.

THE WITNESS: Not

necessarily, no.

BY MR. McCONNELL:

Q. And why not, presuming -- with the understanding that vaginal atrophy occurs in most women naturally and that the mesh is a permanent implant?

A. Well, if you look at the exposure rate in the medical literature for the TVT Secur device, most would agree that it's less than 5 percent, other reports that it's even lower than that, 1.5 percent.

And so if you just look at the body of literature that's out there, most women are not experiencing mesh exposures, and a large percentage of the women that have mesh implanted are postmenopausal.

Q. Are you saying to a reasonable degree of medical certainty that mesh exposure, in Mrs. Burnett now, is not caused by a defect in the TVT Secur mesh?

A. That's correct.

Q. On the next page, paragraph 37, you say Mrs. Burnett -- Mrs. Burnett has no symptoms directly attributed to the TVT Secur mesh exposure.

But what about her anxiety or stress that she expressed to you? Would you consider that to be a symptom of the mesh exposure?

A. I don't recall her voicing a significant amount of anxiety to me during the IME. I don't believe she's on any antianxiety pills or seeking treatment for anxiety, so I'm not clear on the anxiety that you're talking about.

Q. Well, having interviewed her, did she have any concern whatsoever about having mesh exposure in her body? Was it your recollection she stated anything of that nature?

A. She had concern. That's very different than anxiety.

Q. What was her concern?

A. Her concern would be what the future holds for her and what

treatment options are available to her.

Q. Would you consider that concern to be a symptom attributed to her TVT Secur mesh exposure?

A. No, I don't. Symptoms -- I describe symptoms as physical symptoms, so vaginal discharge, vaginal bleeding, burning, dyspareunia, those are what would be considered local symptoms, symptoms located where the complaint is.

And then there's what we refer to as systemic symptoms, that is, the system's response to the exposure, fever, chills, nausea, vomiting. Those things are things that we describe as systemic symptoms.

I don't think people -- a concern is a reaction. That's not a symptom, so that's the way the patient processes the information at hand.

Q. Well, then you'd agree that Mrs. Burnett has a reaction that can be directly attributed to the TVT Secur mesh exposure; correct?

A. I believe that she has concern about it. She's been through a number of IMEs. She's seen a number of experts. She's met with her primary care doctor about it.

But I don't believe she's voiced any anxiety to Dr. Metzger, her long-term physician, or to Dr. Mindrup, her urologist. She's never been insistent that she requires surgery.

To me, she seems to be behaving appropriately based on the local complaints that she has.

Q. In paragraph 38A, you say: Mesh exposure has been estimated to occur in only 2.0 to 4.7 percent of patients receiving the TVT Secur. And you reference an article on that.

In those situations or in those circumstances, what is the reason for the mesh exposure?

A. I don't believe the authors in a meta-analysis or systematic review give a reason. They may mention in the

discussion some of the potential causes, but each one of these is different, so I wouldn't say there's one reason why there's a mesh exposure. There's multiple reasons why mesh can be exposed.

Q. Now, is Ms. Burnett complaining about dyspareunia?

A. She's not.

Q. But that's -- you cite that or you list dyspareunia in 38B; correct?

A. I do.

Q. And why do you do that?

A. Because she claims that she had the following injuries: vaginal mesh exposure, stress urinary incontinence, urinary tract infections.

And I think that oftentimes plaintiffs will complain of dyspareunia as a result of their mesh exposure, so although she hasn't complained about that, it doesn't mean that she won't in the future.

Q. Did you list any other problems that she may encounter in the

future in your report?

A. De novo overactive bladder is listed, vaginal scarring, I listed. So there was a few others beyond the three that were on her complaint form.

Q. In paragraph 39 on the next page, you state: I disagree with Dr. Blaivas on the cause of plaintiff's complaints as the published medical literature on the use of polypropylene as a whole refutes his opinion.

And can you give me a basis for that statement? What literature are you referring to?

A. I'm referring to the Schimpf meta-analyses. There's multiple meta-analyses that he has performed. The TVT Secur registry, the professional statements from the various medical societies, the Cochran reviews.

There's well over a hundred RCTs based on TVT mesh that really do not support Dr. Blaivas' opinions that the mesh is defective.

Q. And you further on in that paragraph list, there's no indication of degradation, roping, curling, particle loss, fraying, contraction, or any other defect alleged by Dr. Blaivas.

Do you see that?

A. I do.

Q. And you say there was no evidence in your exam of such things?

A. Correct.

Q. And what, if anything, in addition to how you -- what you've already described as your exam did you do to rule out or to not find any of those such things?

A. Well, I reviewed Dr. Blaivas' IME and I reviewed Dr. Ann Metzger's medical records, Dr. Shirk's medical records, Dr. Mindrup's medical records. So in addition to my own IME, I looked at plaintiff expert reports and I looked at treating physician reports, and none of the physicians mention degradation, roping, curling, or particle

loss, or fraying, or contracture in their physical exams or in their operative reports.

There's no pathology report that I'm aware of in this case. There was office trimming that was performed, so there was no actual mesh explantation. So that's what that's based on. There's no pathology report. There's no picture. There's nothing documenting any of these alleged product defects.

Q. Now, you're not an expert on warnings; correct?

MR. SNELL: Object; form.

MR. McCONNELL: I'm sorry?

THE WITNESS: I have expertise in looking at warnings in IFUs, patient brochures.

BY MR. McCONNELL:

Q. I'm sorry, Doctor. You have expertise in -- can you repeat that answer? I --

A. Yeah, I have expertise in reviewing warnings, such as the FDA

warning, which would be more properly stated as a public health notification that occurred in 2008. I wrote a response; that the AUA asked me to write a response on their behalf in 2008 in their update series. So I believe that I have expertise in warnings.

I've looked at what the FDA documents had shown.

Q. Well, you haven't done any academic study or you haven't written any literature on the history of warnings on medical products or on any type of device or product, have you?

MR. SNELL: Object; form.

THE WITNESS: In my 2008 -- 2010 -- excuse me -- AUA update, there's a number of paragraphs on how products are cleared by the FDA, what the 510(k) approval process is. I have -- I'm very familiar with that process.

I didn't have a separate publication, but there's a whole

section on reviewing how the FDA clears products, and I have been very familiar with documents that the FDA uses as guidelines for clearing products.

BY MR. McCONNELL:

Q. And how did you come about that? Did you do any -- did you take any courses? Did you do any academic studying? Did you do any literature research or how did you come up with those paragraphs that you reference in the year 2010 response?

A. Well, Ryan Terleki, who was my fellow at the time, him and I wrote the article together. We had communication with the FDA about the warning and they immediately corrected us and said they didn't put out a warning, it was a public health notification.

And then through our literature review on PubMed, we came up with articles that we cited in the update, and so we looked at those

articles on how medical devices are cleared.

I have prepared lectures on this topic, so I've been reviewing this for a number of years. I've shared the FDA public health notifications with my patients. I've looked at position statements from IUGA and AUGS, round-table discussions of experts in regards to the implications of the FDA public health notification.

So I feel I've done my research on this topic.

Q. And those are your criteria for calling yourself an expert on warnings. Am I right?

A. That's correct.

Q. At the end of -- on page 6, towards the end of paragraph 42, you say: The IFU did not in my opinion need to warn about the management of complications or, quote, the difficulty and risks involved in removing the device, because those are also well-known

to pelvic floor surgeons.

Do you see that?

A. I do.

Q. Is it your opinion, Doctor, that there is no need to warn when people are generally aware of a risk?

A. It's my opinion and it's also the opinion of the FDA. The FDA has guidelines for manufacturers looking at prescription devices that they specifically itemize when you need to warn.

And if something is considered public knowledge that a reasonable physician would know and be aware of, that you don't need to warn of that because it's not unique to the product.

MR. McCONNELL: Give me one minute.

(Pause.)

MR. McCONNELL: Doctor, I think those are all the questions I have. Thank you very much.

THE WITNESS: Thank you.

- - -

EXAMINATION

- - -

BY MR. SNELL:

Q. Doctor, I just have a few follow-up questions, and I'm going to start from the back and work -- work backwards actually.

You just mentioned regulations that you're aware of concerning no need to warn when a reasonable physician would have the awareness or knowledge of something that was common across different surgeries or devices; is that correct?

A. That's correct.

Q. And part of what you're relying on, is that the CFR, the Code of Federal Regulations, on labeling, 801.109 - Prescription Devices, where it discusses information that may be omitted from the labeling if the information is commonly known to practitioners licensed

by law to use the device?

MR. McCONNELL: I'll object.

THE WITNESS: That's correct.

BY MR. SNELL:

Q. And the practitioners licensed to use this device, TVT Secur, would that be talking about pelvic floor surgeons like yourself?

A. Yes.

Q. You were asked questions -- and let's turn, if you would, to your report, page 13 -- I'm sorry -- your report at page 1, paragraph 13.

A. (Witness complies.)

Q. Do you recollect discussing with plaintiff's counsel the issue about Dr. Metzger who claimed she felt a sharp edge in the vaginal vault which felt like mesh?

A. I do recall.

Q. Now, I have Dr. Metzger's testimony here. And beginning at page 22, line 23, she's asked about that

bimanual examination.

Do you see that?

A. I do.

Q. And did she say that she found that sharp edge down at the mid-urethra portion of the vagina or at the vaginal vault?

A. It says: A very, very sharp edge at the 9 o'clock in the vaginal vault that felt like mesh, and I remember I almost cut my finger and I took my glove off to look.

Q. And then she was asked again about whether this feeling was at the vaginal vault or somewhere else. And what did she testify as to whether it was at 9 o'clock at the vaginal vault, page 23, line 6?

A. It says: You said it was at the 9 o'clock in the vaginal vault. Answer: That's what it felt like, yes.

So she's agreeing to the question that it was at 9 o'clock and at the vaginal vault.

Q. And then they asked her -- at page 23, lines 17 down through 20, does she describe essentially how large of an area this was?

A. She did. She said: I think it felt like almost 2 centimeters.

Q. And on that topic of whether she thought it was mesh, she was asked: Have you felt mesh exposure before?

And line 25, she says: I don't recall actually ever feeling mesh like -- or, you know, there could be maybe one person, but it was just kind of intertwined within the vaginal vault, but never something this sharp.

Do you see that?

A. I do.

Q. Page 25, lines 14 down --

MR. McCONNELL: Counsel, for completion, can you just read up the page to line 11 on page 25?

MR. SNELL: No, I mean, you can do that, counsel. I'm just asking him about the vaginal

vault.

BY MR. SNELL:

Q. Page 25, beginning at line 14, she was asked the question and does she state whether or not she was actually cut that day?

A. She said: No, I mean -- I mean, I just remember I was not cut that day, but it was sharp, so I thought I was.

Q. And then at page 61 -- this was the examination by one side -- so so far, where exactly was this feeling located, at the area where the sling would be or at the vaginal vault?

A. Are you referring to my exam or Dr. Metzger's exam?

Q. Dr. Metzger's exam, as well as her testimony, sworn testimony, about where this feeling was based on her exam.

MR. McCONNELL: Objection.

THE WITNESS: So based on her exam and her testimony, she says that it was at the vaginal

vault.

BY MR. SNELL:

Q. At page 61, now she was asked again about the conversation she had with Mrs. Burnett about the findings of the sharp edge in the vaginal vault. Do you see that?

A. I do.

Q. And the answer was: Uh-huh. Is that correct?

A. That's correct.

MR. McCONNELL: Objection.

BY MR. SNELL:

Q. So the evidence in this case, Doctor, can you tell us whether Dr. Metzger, based on her exam, her record, and her testimony, indicates that she found this area -- where it was within the vagina?

A. Based on Dr. Metzger's exam and testimony, it was at the vaginal vault.

Q. And you testified that the sling is very far distance away from the

vaginal vault; is that correct?

A. That's correct.

MR. McCONNELL: Objection.

THE WITNESS: Yes, that's correct.

BY MR. SNELL:

Q. Based on your exam of the plaintiff, where was the sling?

A. The sling was 1 centimeter to the right of the urethral -- of the urethra. I felt a 5 by 9 millimeter exposure on the right side. That's on the anterior vaginal wall, underneath the urethra, the bladder.

It's certainly not the vaginal vault.

Q. And do you have an opinion as to whether whatever it was that Dr. Metzger felt at the vaginal vault, whether that was mesh from the TVT Secur?

A. I do.

Q. And what is that opinion?

A. That it was not TVT mesh. That was just a vaginal cuff scar.

Q. And, anatomically, is it even possible that -- based upon your IME exam, that the TVT Secur mesh could have been up in the vaginal vault at the time Dr. Metzger reported finding this sensation?

A. Yeah, it's not possible based on my exam, based on Dr. Blaivas' exam, Dr. Mindrup, and Dr. Shirk. None of the other treaters or experts had ever noted the mesh to be at the vaginal vault.

Q. And because I believe plaintiff's counsel represented that the glove was actually cut, based upon Dr. Metzger's sworn testimony, did she actually have her finger or glove cut?

A. She mentioned that she was concerned, so she took her glove off to see if her finger was cut and, in fact, it was not.

MR. McCONNELL: And I'm going to object to plaintiff's counsel's representation. I was

repeating what Dr. Flynn said for the record.

BY MR. SNELL:

Q. Now, you mention that you've done a general TVT Secur report?

A. I have.

Q. Do you incorporate that and the bases and data set forth in that report into your case-specific report in this case?

MR. McCONNELL: I'm going to object. This is a case-specific deposition, not a general deposition.

MR. SNELL: You can answer.

THE WITNESS: Yes, I mentioned that when I went on the record earlier in the deposition, in terms of the number of hours I worked on this case, I had prepared a TVT Secur report.

I didn't include those hours in preparing this report, but certainly it affected my opinions

in this report, especially in response to the complaints against the device alleged by Dr. Rosenzweig and Dr. Blaivas.

BY MR. SNELL:

Q. And at page 43 -- I'm sorry. I keep getting those pages and numbers -- at page 6, paragraph 43, where you talk about your opinions and the bases and whatnot, do you not state: I hereby incorporate in this report the opinions set forth in my general report regarding TVT Secur device?

A. I do.

MR. McCONNELL: Objection.

BY MR. SNELL:

Q. Have you already sat for a general deposition on those opinions?

A. I have.

Q. Did you do professional education on mesh products?

A. I have.

Q. And as part of --

MR. McCONNELL: Objection.

BY MR. SNELL:

Q. As part of that --

MR. McCONNELL: This is not a general exam.

MR. SNELL: No, it's not. I'm about to tie it to what you asked him about.

MR. McCONNELL: Okay.

BY MR. SNELL:

Q. And when you did professional education on those mesh products, besides talking about the devices or their surgical implantation, did you also cover the IFU steps and the material identified in the IFU?

A. Yes.

Q. And is that a --

MR. McCONNELL: Objection.

BY MR. SNELL:

Q. And plaintiff's counsel asked you about your expertise on warnings. Is that a further basis for your expertise and experience with regard to IFUs and warnings --

MR. McCONNELL: Objection.

BY MR. SNELL:

Q. -- for a device like TVT Secur?

A. Yes, it is.

Q. Do you recall being asked about the urinary tract infections that Mrs. Burnett had?

A. I do.

Q. And you opine that you do not believe that the TVT Secur caused the urinary tract infections.

Let me ask you this question: In paragraph 3, you noted that plaintiff had been treated for at least three urinary tract infections before her TVT Secur implant.

A. That's correct.

Q. And then after TVT Secur, paragraph 8, I only see one urinary tract infection that was referenced.

A. Correct.

MR. McCONNELL: Objection.

BY MR. SNELL:

Q. And then you state at paragraph 15, in 2008, she underwent the laparoscopic Burch procedure; correct?

A. Correct.

Q. And after she underwent the Burch, did she have urinary tract infections?

A. She did. She had, I believe, three urinary tract infections in a short time period following the Burch.

Q. And does that chronology of urinary tract infections, the fact that she had three before TVT Secur at least, one while on TVT Secur, and at least three after the laparoscopic Burch, is that supportive or not supportive of your opinion that TVT Secur did not cause her urinary tract infections?

MR. McCONNELL: Objection.

THE WITNESS: That supports my opinion that TVT Secur did not cause her urinary tract infections. The time course makes

no sense. She had three UTIs before she ever had Secur. She had one UTI immediately following and then had three after her Burch.

She eventually had to see Dr. Mindrup for recurrent UTIs, a urologist. Dr. Mindrup's opinion was that the mesh is not causing her UTIs. He stated that in one of his office notes.

He put her on antibiotics for six months and afterwards was able to stop the antibiotics and has not had an infection since that time.

So I don't believe the TVT Secur or the TVT Secur mesh exposure is the cause of her recurrent urinary tract infections.

MR. SNELL: That's all I have. Thank you.

MR. McCONNELL: I just have

a couple follow-ups.

- - -

EXAMINATION

- - -

BY MR. McCONNELL:

Q. Dr. Flynn, didn't Dr. Metzger refer Mrs. Burnett back to Dr. Shirk after her examination?

A. She did.

Q. And didn't Dr. Shirk at that point perform the excision of mesh in his office on Mrs. Burnett?

A. That's correct.

Q. And wouldn't common sense indicate to you that what Dr. Metzger was feeling was the mesh that Dr. Shirk thereafter excised in his office?

MR. SNELL: Object; form.

THE WITNESS: No, I disagree.

BY MR. McCONNELL:

Q. Why?

A. Again, the location of what she described on her exam and her dep --

and in her deposition, it just doesn't make any sense.

So -- Dr. Shirk is, you know, more qualified to do examinations. I think that he had concerns about a mesh exposure and he excised the mesh exposure. This was a decision that Dr. Shirk made independent of Dr. Metzger.

Q. So your testimony under oath this morning is that a treating physician who felt alarmed at feeling something sharp and thought she may have cut her glove, who therefore then sent her back to the implanting physician who immediately performed an excision of mesh in his office, that your opinion under oath is that you don't believe that what that treating physician felt and was alarmed by was mesh; is that what you're telling the jury?

A. That's what I'm telling the jury, yes.

MR. McCONNELL: Okay.

Thanks very much.

THE WITNESS: All right. Thank you.

(Witness excused.)

(Deposition concluded at approximately 11:10 a.m.)

CERTIFICATE

I HEREBY CERTIFY that the witness was duly sworn by me and that the deposition is a true record of the testimony given by the witness.

It was requested before completion of the deposition that the witness, BRIAN J. FLYNN, M.D., have the opportunity to read and sign the deposition transcript.

_____

KIMBERLY A. CAHILL, a
Federally Approved Registered
Merit Reporter and Notary Public
Dated: July 23, 2016

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)

INSTRUCTIONS TO WITNESS

Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.

After doing so, please sign the errata sheet and date it.

You are signing same subject to the changes you have noted on the errata sheet, which will be attached to your deposition.

It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.

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E R R A T A

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PAGE	LINE	CHANGE

ACKNOWLEDGMENT OF DEPONENT

I,_____, do hereby certify that I have read the foregoing pages, 1 - 92, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

BRIAN J. FLYNN, M.D. DATE

Subscribed and sworn
to before me this
_____ day of _____, 20____.
My commission expires:_____

_____

Notary Public

LAWYER'S NOTES

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